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ABSTRACT

Group counseling presents counselors with an increasing complexity of issues. This collection of papers addresses a range of current issues and perspectives for group counselors. The first article examines self disclosure, particularly the effects of counselor self-disclosure on the therapeutic relationship in group counseling. Clinical supervision of group counselors is outlined next, with a discussion of standards of supervisory practice, ethical and professional issues, and projections for accountability of group counselors. A personal perspective is presented in the following article, in which a practitioner's experience as an African-American co-facilitator of a predominantly white group is used to identify and discuss issues for non-majorities who facilitate such groups. Group work in the treatment of bulimia nervosa is explored next, along with a review of the literature and an overview of the various approaches to the application of group work with bulimics. This is followed by an exploration of the use of cultural identity group counseling with Native Americans college students, featuring an overview of group personality as applied to this population. The final piece examines the use of group interventions as an effective way of addressing the specific needs of Hispanic youth in cultural transition. (RJM)

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A Counseling Monograph

Current Issues and Perspectives in Group Work

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Current Issues and Perspectives in Group Work

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From the Editor

Catherine B. Roland, Ed.D.,
Counselor Educator, University of Arkansas

The six papers included in this monograph were individually written as an assignment for the course *Advanced Group Theory and Techniques*. All six authors are students in the Ph.D. program in Counselor Education at the University of Arkansas. Due to the diversity of topics and current literature reviews, it was decided that we would publish this monograph.

Each author brings a specific expertise and diversity to this piece. Candace Whitfield, M.Ed., LPC, is currently writing a dissertation in the general area of survivors of sexual abuse. She is a private practitioner in Northwest Arkansas.

Michael Loos, M.Ed., is a Graduate Assistant and a Certified Substance Abuse Counselor. Michael is approaching his final semester of coursework for the Ph.D., and plans on writing his dissertation in the general area of loneliness and depravity in addicted persons.

Aretha Marbley, M.Ed., is a Holmes Scholar Graduate Assistant, and has just completed her doctoral comprehensives. Aretha has worked extensively with minority youth and women, and plans on writing her dissertation in the general area of multicultural counseling.

Rebecca Conneely, M.A., is a Graduate Assistant, and the current chapter president of Chi Sigma Iota. Becky brings a wealth of experience as a student personnel specialist, and will approach her final semester of coursework shortly. Becky's dissertation focus is in the general area of eating disorders.

Tarrell Portman, M.Ed., LPC, holds a national fellowship through the U. S. Department of Education Tarrell has been a school counselor, and brings experience with children and adolescents to the program. She is currently the president-elect of our chapter of Chi Sigma Iota, and plans to write a dissertation in the general area of Native American issues and counseling.

Silvia Ruiz-Balsara, M.S., LPC, MFC, is a doctoral student and clinician with expertise in the marriage and family specialty. Silvia has done much work within the Hispanic community, and plans to write a dissertation in the general area of diversity and multicultural counseling.

It has been a unique pleasure to edit the work of my students. I want to expressly thank Rebecca Conneely, who was invaluable as the Assistant Editor of this project.

Self-Disclosure: The Group Counselor's Dilemma

Candace J. Whitfield

This paper reviews pertinent background research in the area of self-disclosure in general with a focus on the effects of counselor self-disclosure on the therapeutic relationship. Because little research has been conducted in the area of counselor self-disclosure in group work, extrapolations will be made from those studies which focused on individual counseling. The research will be synthesized in an attempt to conceptualize guidelines for group counselors in making decisions about their own disclosure while facilitating groups.

Much has been researched and written of self-disclosure in general, as well as self-disclosure in the counseling process. Less has been examined in the area of group counselor self-disclosure. Jourard (1964, 1968, 1971) and Rogers (1961, 1970) have been the most ardent supporters of therapist transparency and self-disclosure as a positive influence in facilitating client self-disclosure in both individual and group work. This was the prevailing thought in the 60's and 70's, during a time when the encounter group movement had become popular (Cozby, 1973; Watkins, 1990). Since that time, an approach more conservative than that of the encounter group has entered the arena of controversy over counselor self-disclosure--an approach reminiscent of the caution (in the area of therapist disclosure) of psychoanalytic theory but also moving closer toward allowing therapist authenticity and involvement. This paper is an attempt to integrate research findings and contemporary thought on group work and counselor self-disclosure into a suggested guidelines for group facilitators.

Self-Disclosure and Healthiness

Self-disclosure is believed to be positively associated with better physical and emotional health (Carpenter, 1987; Derlega, Metts, Petronio & Margulis, 1993; Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Jourard (1964) argued that the ability to self-disclose appropriately is a prerequisite to the development of a healthy personality as well as healthy relationships. In addition, Jourard suggested a curvilinear relationship between self-disclosure and mental health, with either too little or too much disclosure indicating maladjustment (Cozby, 1973).

Derlega et al. (1993) summarized studies which have examined the link between disclosure/nondisclosure and health outcome. Results indicated that concealment of information that is threatening to the self is related to physical and emotional problems. Trauma victims have been studied by Pennebaker, Kiecolt-Glaser, and Glaser (1988), and links between disclosure and immune function documented. Survey results indicated that having experienced an early trauma and not disclosing it to anyone is associated with the greatest incidence of psychological distress and physical illness, as compared with experiencing no trauma or experiencing trauma and confiding about it (Pennebaker, Colder, & Sharp, 1988).

Carpenter (1987) proposed an interference/competence model to explain the relationship between psychopathology and self-disclosure. The essence of this model posits that psychopathology interferes with functioning, including disclosing behavior. In addition, because of pathology, the social skills necessary for appropriate disclosing behavior may not have been learned (or pathology may have developed because of not having been taught appropriate social skills).

The Literature

Older, sometimes groundbreaking, studies are included in this review because they have set the stage for the study of self-disclosure, which has been under investigation for less than three decades. In the past decade, there have been few studies on counselor self-disclosure and even fewer which focused on group counselor self-disclosure.

Client perceptions of counselor self-disclosure have been studied from various angles by numerous researchers. Nilsson, Strassberg, and Bannon (1979) conducted an analogue study which tested hypotheses about perceptions of disclosing and nondisclosing counselors. In this study self-disclosure was separated into categories of interpersonal and intrapersonal. The findings supported the notion that disclosing counselors are perceived more favorably than nondisclosing ones; further, counselors who disclose information about their lives outside of the counseling relationship (intrapersonal disclosure), specifically about ways in which they were similar to their clients, were generally evaluated more favorably than counselors who limited their disclosures to feelings about the client or the counseling relationship (interpersonal disclosure).

May and Thompson (1973) found positive relationships among three therapist variables as perceived by clients: levels of self-disclosure, mental health, and helpfulness. In this study group members also ranked fellow group members on level of disclosure and mental health. There were no differences found in therapist ratings between group members ranked higher or lower on disclosure and mental health. The findings in this study are at variance with an earlier study by Weigel, Dinges, Dyer, and Straumfjord (1972), who found a negative correlation between perceived level of self-disclosure and mental health of therapists. These authors (Weigel et al.) suggest that self-disclosing therapists may violate clients' expectations of appropriate and professional behavior for therapists.

Reynolds and Fischer (1983) investigated counselor self-disclosure designated as self-disclosing or self-involving. This study made an effort to be more definitive about types of counselor self-disclosure. Self-disclosing statements were defined as those made by the counselor about personal experiences or feelings outside the counseling session. Self-involving statements were those personal reactions to the client and the therapeutic relationship shared by the counselor. Results supported previous findings (McCarthy & Betz, 1978; McCarthy, 1979) that counselors using self-involving statements are perceived as more trustworthy and expert than counselors using self-disclosing statements. In addition, Reynolds and Fischer replicated earlier findings (McCarthy & Betz, 1978) that self-disclosing counselor statements shift the focus to the counselor, while self-involving counselor statements keep the focus appropriately on the client and the client's issues.

Client preferences for and anticipations of counselor self-disclosure were examined as they affect ratings of self-disclosing and nondisclosing counselors (VandeCreek & Angstadt, 1985). On all measures, disclosing counselors were rated more positively, regardless of level of preference for or anticipation of a self-disclosing counselor. VandeCreek and Angstadt concluded that future studies examining client expectations should distinguish between preference and anticipation. They surmised that the presence of counselor self-disclosure may produce "pleasant surprise", regardless of a client's initial preference or anticipation, suggesting that counselor self-disclosure/nondisclosure is a more powerful variable than either preference or anticipation.

Curtis (1981) conducted a study with actual clients in a mental health agency, in which impressions of therapist self-disclosure were evaluated according to ratings of empathy, trust, and competence. The client-therapist dialogues (independent variable) were in written form, manipulated to vary across three conditions: high, low, and no disclosure. Findings confirmed the prediction that the more the therapists self-disclosed, the lower were the ratings received on trust, empathy, and competence. Because this was a well-controlled study which utilized real life clients

rather than college students, the results and indications for clinical practice appear well worth further study.

Watkins (1990) reviewed the literature on the effects of counselor self-disclosure, evaluated the research, and made recommendations for future research. Of all the 35 studies evaluated by Watkins, only one (Curtis, 1981) used actual clients rather than college students. All of the studies were analogue in nature and focused on the initial counseling interview. It is important to note that these studies were scrutinized by Watkins according to Strong's (1971, cited in Watkins, 1990) five boundary conditions for generalizing laboratory findings to the counseling situation. These conditions are:

> (a) counseling is a conversation between or among persons, (b) status differences exist between the interactants and constrain the conversation, (c), the duration of contact between interactants is considered, (d) the degree of client motivation to change is assessed, and (e) the degree of client distress is determined. (Watkins, 1990, p. 480)

None of the these five conditions were met in the 35 studies that Watkins reviewed and evaluated, indicating that generalizing and implementing results to real life clients might be hazardous to both counselor and client.

The characteristics of counselor self-disclosure were surveyed by Edwards and Murdock (1994). Respondents were members of the American Psychological Association who were practicing psychotherapy, and results indicated that participants were disclosing most often about professional credentials and experience and mainly for the purpose of increasing similarity to clients. As Edwards and Murdock concluded, the most mentioned motive for disclosure (to increase therapist-client similarity) did not appear to fit the content of what was said to be disclosed most frequently (professional credentials and experience). In other words, disclosure of credentials to clients would appear to increase the power and status differential between counselor and client. Edwards and Murdock analyzed their data to look for gender and ethnic group effects and found no significant differences. They did find differences relative to theoretical orientation, with analytics reporting the least amount of self-disclosure and both humanists and behaviorists reporting the greatest, which corroborates Yalom's (1995) belief.

Hendrick (1990) reported a study which examined client preference for types of counselor disclosure. The sample consisted of persons seeking counseling at an outpatient clinic. Those who participated filled out a brief questionnaire. The client sample indicated interest in a counselor's feelings, relationships, professional issues, failures and successes. Very little interest was found for disclosures about a counselor's attitudes, and the least interest was found for sexual issues. Hendrick described the study as a pilot effort with the usual limitations, including the small sample size (24, half of which were women). She concluded that this does not indicate that counselors should disclose just because the client desires it--that the decision to disclose "must be made by the counselor on the basis of the particular situation." (p.185)

In examining group therapist self-disclosure, Dies (1973) found a positive relationship between length of time in therapy and more favorable attitudes toward counselor self-disclosure. However, even though self-disclosing counselors were rated as more friendly, trusting, intimate, and helpful (Factor 1), they were also judged to be less stable, sensitive, relaxed and strong (Factor 2). Dies concluded that the results provide no definitive answer about the effect of group counselor self-disclosure, except that it is impacted by the length of time in a treatment group as well as other treatment variables, such as the experience and competence of the group leader, the nature of the self-disclosure itself, and the type, purpose, and composition of the group.

Robitschek and McCarthy (1991) assessed by survey the frequency of self-referent counselor statements, categorized as either self-disclosing ones or self-involving ones, and as

either positive or negative. Male and female counselors of varying experience and ethnicity participated. The hypothesis that counselors use more positive self-referent statements of both types than negative ones was confirmed. No differences were found as a function of either gender or level of experience, and differences due to ethnic background were not analyzed.

Therapist self-disclosure was investigated by Hill, Mahalik, and Thompson (1989) with a focus on the effects on helpfulness and level of client "experiencing" (self-exploration, depth of involvement). Therapist disclosures were rated by both therapists and clients as self-disclosing or self-involving and as positive or negative. Results indicated that self-involving/reassuring disclosures were rated by clients as more helpful than challenging self-involving statements and either reassuring or challenging self-disclosures.

Morran (1982) proposed that group facilitators limit their disclosures in terms of frequency and intimacy in early group sessions. This recommendation concurs with Dies (1973), who stated that group leader behavior which may be deemed inappropriate at one stage may become more congruent with the intimacy level of the group as it develops and moves into later stages. The parameters of amount of self-disclosure (frequency), intimacy level of the disclosure, and duration of the disclosure have been identified by Cozby (1973) as important considerations for counselor self-revelation.

Other authors have warned that appropriate therapist self-disclosure is only that which has the client's best interest in mind (or at heart), e. g., promotes trust in the counselor, improves the therapeutic relationship, and facilitates client self-disclosure and positive outcome (Edwards & Murdock, 1994; Miller, 1983; Watkins, 1990). Yalom (1995) stresses that a group leader's disclosures must be conducive of group members reaching their goals for group work. Group leaders who are willing to share their honest reactions to what is happening within the group are more likely to assist the growth of healthy interpersonal relationships (Corey & Corey, 1987).

The effects of gender, race, and ethnic or cultural background have been examined by very few studies on self-disclosure. In some studies reviewed by Watkins (1990), neither counselor nor client gender was considered in data analysis. In the studies which included gender of counselor as a variable, no significant differences were found in perceptions of counselor disclosure (Watkins, 1990). He concluded that no counseling implications can be drawn from the results as they now stand. Cherbosque's (1987) study indicates that race and cultural variables may affect perceptions of counselor disclosures differentially, but that much more research is called for before stating implications (Watkins, 1990).

Wells (1994) has recently offered the only published qualitative study to date examining the effects of therapist self-disclosure on clients and the treatment relationship. She interviewed eight subjects, who had previously been in individual psychotherapy, about their experiences with counselor self-disclosure. Participants were asked to reflect on the context of therapist disclosure, their responses to the revelations, their perceptions of therapist disclosures on their therapy and the relationship, and their views about the appropriateness of the disclosures. The most significant findings were that nearly all participants "described some degree of inhibition around revealing and exploring feelings following the therapist's self-disclosure" (p. 37). This finding is most significant because counseling/therapy needs to be a supportive relationship where the client is provided a safe environment in which to disclose and explore feeling and experience. Whatever detracts from this goal would be considered detrimental to the client's best interests.

Although most of the participants in Wells' (1994) study reported uncomfortable emotional reactions to their therapists' self-disclosures, they also reported not discussing these feelings with the therapists, thus censoring their own disclosures. Wells recommends that practitioner-training programs integrate guidelines for appropriate counselor self-disclosure into existing curricula.

Limitations of Previous Research

Methodological problems plague the research on self-disclosure, making it nearly impossible to reach conclusions based on solid, nonconflicting evidence. As Hendrick (1987) states, it is a matter of thematic problems across the literature rather than any one study, since limitations can be found within each study. For many years, the lack of a common language base and operational definitions of self-disclosure was a problematic issue (Watkins, 1990). As other variables began to be examined which impacted counselor self-disclosure, and self-disclosure became more specifically operationalized in various studies, the complexity and multidimensional character of the construct of self-disclosure became apparent. The analogue nature of nearly every study, as well as the use of students rather than actual clients, is also problematic (Hendrick, 1987; Watkins, 1990).

Indications for Future Research

The study of counselor self-disclosure and its effects on counseling outcome should be moved into the field and studied in depth, perhaps with more qualitatively-oriented methods. Otherwise, research may continue indefinitely with the same mixed and conflicting results, leaving practitioners with the same questions about whether, when, and how to utilize self-disclosure.

Client expectations are an important variable in the disclosure literature, and Hendrick (1990) has attempted to address this issue by asking clients directly about desired disclosure from counselors. Peca-Baker and Friedlander (1989) suggest that a "fit" between disclosure by the counselor and that desired by the client may enhance counselor attractiveness, while counselor self-disclosures unsolicited by clients may add nothing or even detract from the counseling relationship.

Watkins (1990) recommends studying the effects of counselor self-disclosure beyond the initial session, as well as making what is studied congruent with what is taught and practiced. In other words, the counseling relationship is believed to develop over time and not in the initial interview. The positive relationship found by Dies (1973) between length of time in counseling and more favorable attitudes toward counselor disclosure indicates that initial session analogue studies need to be forsaken for longitudinal ones, to be done qualitatively.

A mini-set of guidelines for group counselors have been extrapolated from the research on counselor self-disclosure, bearing in mind that to date there has been no longitudinal or qualitative research examining group counselor disclosure as it affects the therapeutic relationship and, ultimately, counseling outcome.

Guidelines

1. First, do no harm. It is a given that the client's well-being and best interests are the guiding principle.
2. Distinguish between self-disclosing and self-involving statements. Self-involving statements share the counselor's here-and-now responses to and experiencing of the client and the therapeutic relationship/process. Self-disclosing statements shift the focus from the client/client's issues to the counselor--always risky business.
3. Consider the quality of the relationship, e.g., level of rapport and trust, amount of client resistance, client's capacity for insight and self-acceptance.
4. Consider length of time in counseling. In general, the longer the time, the more relaxed and intimate the relationship, making client acceptance and integration of counselor disclosures more favorable and helpful.
5. Consider the expectations of the client about the therapy process and the professional role of the counselor. Also consider client expectations grounded in cultural, ethnic, and socioeconomic backgrounds.

6. Refrain from self-disclosure in the presence of serious pathology. For example, those clients diagnosed borderline, dependant, and paranoid personality-disordered, may misinterpret counselor self- disclosures, derailing the development of healthy boundaries. Self-involving statements would seem to be more effective for giving the client feedback on how others may be experiencing them as persons.
7. Consider the purpose and focus of the group. In some focus groups, counselor self-disclosure may be more appropriate than in others. Consult with another counseling professional if this is not readily apparent.
8. Consider the length, purpose, frequency, and timing of counselor self-disclosures. In general, brief in length, low in frequency, for the purpose of meeting the client's needs rather than the counselor's, and in the later stages of the relationship rather than initial stages.

Wells (1994) found these reasons for clients' increased inhibition after therapist self-disclosure:

> clients wanted to protect the therapist and be sensitive to his or her feelings; they did not want to elicit a response from the therapist which would stir up unresolved emotional material; and/or they felt the therapist was incapable of providing a safe emotional environment for exploration. (p. 37)

These findings indicate that counselor self-disclosure should be used with the utmost caution and care, taking into account the guidelines listed above.

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Clinical Supervision of Group Counselors: New Perspectives

Michael D. Loos

Standards of supervisory practice are discussed in this paper. Current and future healthcare projections for accountability of group counselors is an area that counselor educators must addres. . in terms of training group counselors. Ethical and professional issues are addressed.

There is dramatic restructuring occurring within the nation's healthcare industry. The impact such renovations will have on the clinical supervisor of counselors in group training is not clear. According to a recently released task force report summary (Pew Health Professions Commission, 1995), projected fundamental changes will focus on: 1) the development of uniform standards within a profession; 2) practitioner education and training; 3) effective continuing competency assessments; and 4) practitioner accountability to both the profession and the public served.

Of particular interest is the impact of these projected regulatory guidelines, and the effect they might have on the training of group counselors. The clinical supervisor's role then becomes more regulated as education, training and practice are held out for public scrutiny. The purpose of this article is to examine each of the four projected areas of change (standards, preparation, competency and accountability) in light of the current status of clinical supervision in the training of group counselors.

Current Standards

The Association for Specialists in Group Work (ASGW) revised standards (1992) outlines the core competencies in general group work. The ASGW has identified specific tasks, knowledge and skills that provide the foundation upon which effective training is constructed. Although addressing the minimum competencies for training, replete with clock-hour minimums, the standards appear not to regulate the practitioners who provide the mentoring and monitor a trainee's progress toward skill acquisition.

The core competencies for clinical supervisors of the Association for Counselor Education and Supervision (ACES) might provide a basis in formulating an appropriate nomenclature (Borders & Leddick, 1987). Although supervisory knowledge and skills are not typically different, the venue in which they are exercised may be quite distinct. Because group counseling is significantly different than individual counseling, the public may be left with questions about the quality of training of the practitioner delivering those services, thus expecting that the cadre of clinical supervisors be expert in terms of their ability to adequately prepare the group practitioner. There are differences in conceptual skills, knowledge base, interventions and management requiring specific group supervisor training prior to overseeing the development and training of other group practitioners.

According to the American Counseling Association (ACA) Code of Ethics and Standards of Practice, Section F.1.f. and Section F (SP-38)(1995), the preparation of clinical supervisors is addressed in less than specific language, particularly for the group training supervisor. The content of these standards would require amendment to include a statement of minimum competencies relative to philosophical foundations, practice dimensions and level of academic and experiential training. A composite definition clearly delineating the core competencies required of

the effective clinical supervisor in training group counselors is essential for the profession. For those in the role of mentor-model, such clarity may be appreciated and well received. Group treatment and counseling reflect efficiency and conservancy and, therefore, will be subject to increasing public review.

Both the Association for Specialists in Group Work and the American Counseling Association have produced standards that guide the preparation of counselors. Invariably, the more general areas of education and training overlap significantly. The ACA promulgates general guidelines for the practice of clinical supervision adopted by many preparatory institutions and licensing boards. The guidelines are not specific to the preparation and training of the skilled group training supervisor. Under the previously cited Code of Ethics and Standards of Practice, a general description of the knowledge base is expected of an accomplished instructor. The ASGW's revised standards focus on the core curricula standards for knowledge and skill competencies of group counselors. Additionally, the ASGW provides descriptive guidelines for specialty areas of group practice, that are founded by domain, knowledge and skill development. What is missing are detailed guidelines that attend to the preparation of the clinical supervisor who plays an irrefutably important role in the development of the group practitioner.

Exactness, as implied in the Pew Report (1995), is the principle by which practitioners will be evaluated in terms of practice preparation, and clinical supervisors will be judged as effective mentors. To meet this criterion, counselor education programs will need to offer course-specific requirements for group training supervisors that first encompass the acquisition and appreciation of the components of theory and technique, then provide the opportunity to carefully monitor technical competence in the practice of that body of knowledge and set of skills (Borders & Cashwell, 1992; Borders & Fong, 1994). The Council for Accreditation of Counseling and Related Education Programs (CACREP) (1994) offers standards that address the cogency of these issues in the preparation of counselors in general and group counselors as a part of that whole. The CACREP standards outline the necessary curricular experiences for marriage and family counseling, gerontological and community counseling, school counseling and mental health counseling. It would be advantageous to add to this structured format the requirements for clinical supervision, especially for the group training supervisor. This would enhance the credibility of the practitioners graduating from CACREP-approved programs.

Many researchers and educators recommend some form of experiential group participation as a fundamental component of preparatory training (Berger, 1993; Glickauf-Hughes & Campbell, 1991; Lenihan & Kirk, 1992; McAuliffe, 1992; Merta, Wolfgang, & McNeil, 1993; Newman & Lovell, 1993; Ravets, 1993; Stempler, 1993; Tuttman, 1991; Weber, Costikyan, Fales, & Morgan, 1995; White & Russell, 1995; Wilbur, Roberts-Wilbur, Hart, Morris, & Betz, 1994). Proctor (1994) and Kibel (1990) specifically refer to supervision as the most significant influence in the final phase of professional preparation. A consistent theme embedded in the literature is that nothing is more integral in the development of the group counselor than exposure to and guidance from an effective clinical group supervisor. As Proctor (1994) so distinctly states, the main criteria for selection as a clinical supervisor often has been based on proximity, theoretical orientation, acceptance of someone who has been suggested and, more often than not, on who one has been appointed.

Competency

Establishing and assuring the continuing competency of practitioners looms large. Those responsible for training practitioners must document and demonstrate the personal and professional preparedness to provide adequate, effective group clinical supervision. The curriculum guidelines available through the ACA's professional divisions provide for the adequate preparation of the skilled supervisor in general but not specifically the group supervisor.

Another general subject alluded to in the literature indicates that, historically, the competence and experiential success of a mentor was sufficient criteria to judge competence (Proctor, 1994). Soon it will require more than academic expertise and longevity of practice to establish credibility and competence. Outcome data, defined as measures or documentation of some fashion, specific to capability as an educator, counselor, trainer and supervisor will be a required benchmark of continuing competence.

Next, the maintenance of competence will need to be addressed and measured. Attendance and participation at supervision workshops may become mandatory for group supervisor practitioners. In the counseling marketplace, if proposed and adopted by the ASGW, this precept could become the standard by which the group counseling discipline demonstrates a commitment to professionalism. Dye and Borders (1990) concluded that as a fundamental goal, to ensure quality service for the public served, effective supervisors for competent counselors should not be forgotten nor, as stated in a later publication, neglected in post-degree practice (Borders & Usher, 1992).

Training Issues

Demonstrating and documenting effectiveness as a group counselor supervisor is rigorous, touching every aspect of counselor development, from preparation to practice, to personal introspection. For the group training supervisor, this responsibility extends to the protection of the profession from the adverse impact of the ill-prepared practitioner. The protection of the training supervisor from the ethical dilemmas and potential sanctions stemming from disgruntled students with whom the training supervisor may have worked is another consideration. Ideally, both the supervisor and the student share the commitment to promote public and personal well being, to develop professionally, and to practice ethically. However, it is the training group supervisor, whose credentials will be exposed, who will be challenged to demonstrate that the students whom the supervisor has prepared can pass muster. It will be the training group supervisor who must help uncover the tacit knowledge of the student and articulate the relationship of knowledge to practice (Holloway, 1994). To appreciate the seriousness of this issue, let us consider how we train our future group counselors.

The principle methods of imparting information include both didactic and experiential exercises. It is easy enough to document the acquisition of a knowledge base through papers and written exams. Accomplishing this goal with the experiential component is quite another story. As mentioned earlier, the predominant models of training of group counselors include experiential groups (Merta, Wolfgang, & McNeil, 1993). Holloway (1994) contends that the connection between ideas and experience allows for greater understanding of an event in a full and passionate way, thus emphasizing the importance of experiential groups. Holloway further states that this training supervision practice better facilitates professional competence and ability to devise more effective strategies in working with clients. Experiential group supervision presents the training supervisor with a number of uncomfortable issues with which the supervisor must deal (Ellis & Douce, 1994). Some of these focus on control and power issues in supervision (Salvendy, 1993). Other researchers cite frequent dilemmas with the issue of dual relationships (Lloyd, 1990; Merta et. al., 1993). The complex responsibilities of the group clinical supervisor now become evident. Both legal and ethical issues that deal with competent practice and the role of the clinical group supervisor in assuring said competency must be considered (Stoltenberg & Delworth, 1987).

Options

Much has been written about clinical supervision in the past decade. Some writers suggest that supervision is a professional discipline worthy of designation as a distinct field of practice (Dye & Borders, 1990). There are guidelines for training supervisors and many models have been proposed (Stoltenberg & Delworth, 1987). There is a growing body of literature regarding group

work published by the Association for Specialists in Group Work. The Association for Counselor Education and Supervision offers a distinct curriculum guide for the preparation of counseling supervisors (Borders, Bernard, Dye, Fong, Henderson, & Nance, 1991). Currently, the ASGW offers no separate guideline for the preparation of group training supervisors.

It would be helpful for the ASGW to develop and establish a measurement system that embraces both the oral and written traditions to ascertain continued competence of the group supervisory practitioner. The written component can be based on the acquisition of knowledge regarding state-of-the-art techniques; the oral component can be based on a criterion-referenced case management presentation defense.

Attention would be given to the construction of a role delineation study to develop standards for the specialty practice of "Group Training Supervisor" within the ASGW. Something so germane to the effective clinical preparation of group counselors must require more than the casual reference it is given in preparatory guidelines regarding curriculum training of supervisors (Borders, Bernard, Dye, Fong, Henderson, & Nance, 1991). This is particularly true in that group work and group work training have become, each in its own right, distinct professional disciplines.

Conclusion

With the advent of healthcare workforce regulation reforms, there will be: 1) increased emphasis on a system that promotes uniformity of standards of professional practice; 2) focused attention on the acquisition of a knowledge base and technical competence with its use; 3) a demand for quality care and continued demonstration of competence; and 4) a public concerned with accountability as measured by treatment outcome. All of these factors will impact the group counseling discipline. We can temper the effects of this transformation by exercising foresight in regard to addressing some of the more obvious shortcomings in our group counseling preparatory guidelines. The ASGW is encouraged to revisit the standards for the training and development of group counselors to include some more specific guidelines and language addressing the competencies of the group training supervisor. The development of a scope of practice manual to augment the standards of practice would facilitate public understanding of the nature of group work and group counseling.

Further discussion on ethical dilemmas could focus on the more prevalent of the challenges, including transference, dependency, power and dual relationships issues (Kurpius, Gibson, Lewis, & Corbet, 1991). Additional attention must be given to update the newly credentialed group practitioner with the most common ethical sanctions and how to protect counselors and the public from potential harm (Neukrug, Healy, & Herlihy, 1992).

Scholar-practitioners responsible for the education and training of group counselors and clinical group supervisors should do further research on assessing the components of quality group training and professional development of competent group training supervisors. As the demand for more and competent group practitioners increases so, too, will the demand increase for assurances that these practitioners are adequately prepared. With this will come added responsibilities for the clinical group supervisor and a need for improved preparation of these mentor-models.

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There's More to the Apple than Meets the Eye: Perceptions of an African-American Co-Facilitator of a Predominantly Majority Group

Aretha Marbley

The author uses her experience as an African-American co-facilitator of a predominantly white group to identify and discuss unique and common issues for non-majorities facilitating majority or different race groups. Included in the group dynamics, but often not addressed in counseling groups, are feelings and experiences of racism, prejudices, and oppression that are present in both practitioners and group members.

When addressing multicultural issues, most researchers have focused on the diversity of the clientele rather than the cultural diversity of the practitioner (Gainer, 1992; Ivey, Ivey & Simek-Morgan, 1993; Ponterotto, Casas, Suzuki & Alexander, 1995; Sue & Sue, 1990).

The purpose of this article is to discuss the issues inherent in a group situation where there is a non-dominant group leader. The article chronicles the perceptions and experience of facilitating such a group and includes personal reactions about the experience of an ethnic-minority co-facilitator of a majority group. The author is an African-American counselor who had the opportunity to co-facilitate a culturally diverse group. However, this group was not the traditional multicultural group made up of minority members, but one that consisted of mostly majority group members.

Review of the Literature on Diversity and Group Work

The literature on multicultural and/or diverse groups referred mostly to racially and ethnically different groups, which includes important factors for the facilitator of any diverse group (including white groups). Underestimating the importance or a lack of awareness of the impact of race and/or ethnicity in group work may actually hinder the counseling process and outcome of treatment (Greeley, Garcia, Kessler & Gilchrest, 1992; Ivey et al., 1993; Ponterotto et al., 1995; Sue & Sue, 1990).

One prerequisite and essential component of effective counseling with multiracial or multiethnic group members is an awareness of one's own culture and cultural values and norms (Ivey et al., 1993; Ponterotto et al., 1995). This examination begins with the group facilitator but must include the members. Greeley et al. (1992) offered that "All counselors and clients exist in a multicultural environment that necessitates understanding one's own as well as others' cultures" (p. 197).

In a cross-cultural group setting, Yalom's (1995) therapeutic factors, or view of the group as a social microcosm rings true; that is, group members bring with them to the group their values, beliefs, prejudices, and racial biases, and will reenact them in the group setting. "Given enough time group members...will create in the group the same interpersonal universe they have always inhabited (p. 28). As a result, the author tuned in to observe the group members' reactions to her as an African-American group leader.

"Our thoughts, feelings and attitudes regarding race differences form the basis of prejudice and are believed to act as the foundation of our behavioral responses in intergroup contexts."

(Allport, 1954 as cited by Johnson, Torres, Coleman & Smith, 1995). Racism and cultural bias impede the counseling process (Brown, Lipford-Sanders & Shaw, 1995; Greeley et al., 1992; Pope-Davis & Ottavi, 1994; Sodowsky & Plake, 1992; Steward, 1993; Sue & Sue, 1990). Racism, prejudice, sexism, and internalized oppression are very emotional issues and may impede or prevent goal attainment both of individual and group counseling (Johnson et al., 1995).

Gainor (1992), reflecting on group work with African-American women, says that an effective African-American female group leader must confront and deal with her own internalized oppression. Reynolds and Pope (1991) define oppression as "a system that allows access to the services, rewards and benefits, and privileges of society based on membership in a particular group" (p. 174). Failure to confront these issues may have identifiably different outcomes for African-American women group members.

Racism, prejudice of many kinds and internalized oppression are real issues in multicultural group work and can be viable elements in blocking effective group counseling (Gainor, 1992; Johnson et al., 1995; Rollock, Westman & Johnson, 1992; Yu & Gregg, 1993). In fact, Gainor (1992) has found that "expressions of internalized oppressions within the group process can actually serve as invitations to developing deeper and more meaningful interpersonal relationships and greater group cohesiveness" (p. 241).

The counselor must increase his or her knowledge and information about other cultures, especially the culture(s) of the populations that he or she will be working with. In short, the counselor must become culturally intentional. According to Ivey et al., (1993), the person who acts with intentionality is a fully functioning person who has a sense of capability. She or he can generate alternative behaviors in a given situation and 'approach' a problem from different vantage points. Greeley et al. (1992) state that a counselor who is aware of a particular culture's behaviors and attitudes may become sensitized to how such values and attitudes may interact and affect the dynamics of a group, and decrease the chances of culturally bound behaviors being misrepresented as pathological.

The assessment of racial identity or racial consciousness can be critical in facilitating a racially mixed group or culturally diverse group (Bell, Bouie & Baldwin, 1990; Gushue, 1993; Hinkle, 1994; Ponterotto, Rieger, Barrett & Sparks, 1994). Pope-Davis and Ottavi (1994) concur that contrary to the experiences of most ethnic groups, White Americans are rarely called on to assess their own attitudes about their white ethnicity. According to Greeley et al. (1992) a starting place for this assessment is with instruments created to assess stages of racial identity development. Some of the instruments are the White Racial Identity Attitude Scale (WRIAS; Helms, 1989 as cited by Greeley et al.); and the White Racial Consciousness Development Scale (WRCDS; Claney & Parker, 1989 as cited by Greeley et al.).

Rollock et al. (1992) feel that white professionals who do not increase their cultural knowledge have propensities toward over-pathologizing, and the refusal to take on other roles to deal with practical problems tend to undermine the therapeutic effectiveness. Non-white professionals working with a white clientele in a counseling situation, who are ignorant of culture knowledge, run the same risks of therapeutic ineffectiveness.

Self-awareness and self-assessment co-exist and are not separate entities. According to Greeley et al. (1992), self-awareness starts with self assessment; that is, knowledge of one's racial or cultural identity development. With this in mind, for a non-majority group leader to emerge as a competent and an effective counselor in this predominantly white group or other groups composed of ethnic or racially different members, he or she must be comfortable with their own racial identity. To feel this, the practitioner needs to be at an advanced developmental stage of racial awareness.

Johnson et al. (1995) firmly states that "Counseling outcomes in culturally diverse groups are dependent, in part, on the match between the group leader's and the client's respective stages of racial consciousness" (p.145). Helm cautions, that "a counselor cannot move the client further than the counselor has come in terms of racial identity" (p. 495).

Based on racial-consciousness developmental stages, Helms (1984 as cited by Gushue, 1993) proposes a number of different patterns of the counselor and client relationship: 1) The correspondence of racial-identity stages can be parallel (counselor and client at equivalent stages); 2) progressive (counselor at least one stage ahead of client); 3) regressive (client is at least one stage ahead of counselor); or 4) crossed (client and counselor at affective opposites in their feelings toward Black and white).

The Group Experience

The group was an experiential, personal growth group, that was a requirement for a masters level introductory group course at a major university. Facilitation of the group was the major requirement for an advanced doctoral level group course. The group was composed of all women: one African-American, four European Americans; and two co-facilitators, an African-American and a European-American.

While observing a taped interaction with a Caucasian member of the group, the doctoral students in the class and the instructor commented that the group member consistently responded to the African-American facilitator superficially. Class members did not notice this superficiality when the group member responded to the white co-facilitator. The author was surprised and quite puzzled, because she had felt the group member was being genuine and profound in her interactions with her, and had not sensed what the observers seemed to sense.

The following questions surfaced: 1) If the class and instructor were accurate in their assessment, why was the African-American facilitator unaware of it; 2) if it was true, why; and 3) if it wasn't true, then what was being observed?

Initial thoughts centered around competency as a culturally diverse group facilitator, and preparedness for cross-cultural counseling. Research in multicultural counseling asserts that group leaders must be aware that racially diverse groups may have issues relating to their cultures that warrant considerations (Brown et al., 1995; Pope-Davis & Dings, 1994; Reynolds & Pope, 1991; Steenbarger, 1993; Sue & Sue; 1990). Also, to be effective the group leader must have some knowledge or familiarity with the culture (Brown et al., 1995; Greeley et al., 1992; Rollock et al., 1992; Yu & Gregg, 1993). Sue and Sue (1990) maintained that the principle goals for culturally skilled counselors are to become aware of their own assumptions about human behavior, to seek an understanding of clients' assumptions about human behavior, and to become active in developing appropriate intervention strategies.

White middle class culture still dominates and is the primary culture represented in the research and literature in education and mental health (Sue & Sue, 1990; Ivey et al., 1993). This is echoed by Ponterotto et al. (1995) who stated that

> . . . even the shortest glance of the most notable journals . . . shows a naive Eurocentric approach. The growing influence of multiculturalism is recognized, but they are still clearly a minority vote. . . . look at the number of people attending multicultural presentations at an APA convention to know where the balance of power still lies (p. 56).

Race issues are prevalent, such as prejudice, racism, and discrimination, and when groups of mixed races exist, those issues, feelings or behaviors do not magically disappear. There is truth in Yu and Gregg's (1993) remark that "the presence of a culturally different person in a counseling group has more implications than a mere difference in birthplace or ethnic origin" (p. 87).

The quest for answers may have started with the author's class response to a taping of that group, but it quickly expanded to included observations of the group responses to her and to her co-facilitator. It absorbed the interactions of the group members to group members, group members to group facilitators, and the group members reactions to the responses and interactions of the various group dyads.

As an African-American, the author understood that there were more differences within groups than between groups, and as a rule, she was aware and committed to acknowledging individual differences and above all recognizing and respecting those individual differences in a counseling situation.

Implications and Suggestions

If the multiculturalism movement is to totally emerge and be recognized fully as a fourth force in counseling, then the focus cannot remain on ethnic minorities and other culturally diverse groups as different. It must recognize and emphasize the dominant group as having racial, cultural, and ethnic differences.

Clearly, if multicultural group counseling is to be effective, research and training must put more focus on the roles of culturally different practitioners in heterogeneous or homogeneous groups. There must be more research done in this area, including research based guidelines for the training and supervision of multicultural practitioners. More research in multicultural group work, training issues and guidelines, and practical applications for non-majority counselors facilitating white or different race groups is needed.

It is hoped that researchers, counselor educators, and practitioners interested in or currently working with multicultural groups will continue to publish reports of their experience. It is also hoped that more research studies involving group work using a multicultural approach will be mounted.

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Group Work in the Treatment of Bulimia Nervosa: An Overview of Approaches and Efficacies

Rebecca J. Conneely

Group psychotherapy has emerged as the preferred modality in the treatment of bulimia nervosa. An examination of the various approaches to the application of group work with bulimics is accompanied by a brief discussion of the symptoms and etiology of this eating disorder. A review of recent literature will explore the link between the theoretical formulations of the disorder and the chosen treatment approach. Considerations for therapists who facilitate groups with bulimics will also be presented.

The use of group therapy has become increasingly recognized as an effective mode of treatment for bulimia nervosa. This is likely due to the suitability of group work to a number of the traits associated with bulimia. Bulimia nervosa is an eating disorder of behavioral, psychological and physiological symptoms, characterized by overwhelming urges to eat large quantities of food, followed by guilt-driven efforts to compensate for the calories consumed through purging behaviors. The core issues of the disorder are: (1) an extreme preoccupation with weight and body size or shape; (2) frequent, uncontrollable urges to overeat; and (3) the purging behaviors to counteract the effects of binge eating (Harper-Giuffre, 1992).

Bulimics typically carry out their behaviors in carefully-guarded secrecy, and experience hopelessness, shame and confusion over the symptoms of the disorder. Group work provides a therapy which offers social support, universality, a safe place to break the secrecy and express emotions, and a place where realities and distorted perceptions can be tested and challenged (Zimpfer, 1990). Duncan and Kennedy (1992) would add to this list of benefits the opportunity to help as well as be helped, a sense of empowerment through participation in the process of treatment, and the instillation of hope through seeing others on the way to recovery.

Treatment of Bulimia Through Group Work

The interpersonal dynamics that occur within the structure of groups have distinct therapeutic benefits. As a group of individuals progresses through the experience of working together on a common task, a sense of group identity will gradually emerge. The group becomes a social system whose purpose is shared by all members; in the midst of this process, therapeutic change can occur for the individuals (MacKenzie & Harper-Giuffre, 1992; Yalom, 1995).

Critical to the effective functioning of a therapeutic group is the development of group cohesion, described by Yalom (1995) as a condition in which group members feel comfortable and accepted in the group and feel as though they belong. Participation in the group is an attractive experience, and one to which the members remain committed. MacKenzie and Harper-Giuffre (1992) identify a cohesive group as one which is characterized in part by regular attendance, a stability of membership, and high levels of participation, risk-taking and self-disclosure.

MacKenzie and Harper-Giuffre (1992) summarized a number of other therapeutic factors which have been identified as having a positive contribution to effective change in the group process. These factors have been grouped into the following four categories: (1) supportive factors; (2) self revelation factors; (3) learning from others; and (4) psychological work factors.

The advantages to therapeutic groups result, in part, from the variety of relationships which can develop, and the multiple sources of feedback and learning (MacKenzie & Harper-Giuffre).

In general, the goals of treatment for eating disorders include normalizing weight and eating patterns, overcoming pathological attitudes about the body, self-esteem and relationships, and increasing personal coping skills, as well as social support resources (Levine, Petrie, Gotthardt & Sevig, 1990). There are, however, a variety of different approaches and purposes in using group work with this population, ranging from self-help groups to support groups to group therapies from different orientations (Levine et al., 1990). The differences in these groups are apparent in both their leadership and in their goals.

Self-help groups are conducted by peers, typically without the involvement of a trained professional. The function of self-help groups tends to focus on eliminating the symptoms of eating disorders through structured programs and peer influence. Support groups, in contrast, are usually facilitated by professionals, but can be conducted by recovered lay-persons. In these groups, the focus is on group members serving as support for one anothers' needs for empathy and encouragement. Education can also be a component of support groups (Levine et al., 1990; Rice & Faulkner, 1992).

The more therapeutic purposes of groups can encompass psychoeducation, long-term intensive therapeutic interaction and exploration, or strictly the function of bringing serious or dangerous eating behaviors under control (MacKenzie & Harper-Giuffre, 1992). Common themes which emerge in therapy groups for eating disorders include: (1) coming to terms with the diagnosis of an eating disorder; (2) understanding that the disordered behaviors must be relinquished; (3) identifying ways to replace the function the disorder has served; (4) exploring family roles and alliances; (5) acknowledging difficulties with trust, assertiveness and attitudes of perfectionism; (6) recognizing the tendency toward all-or-none thinking; and (7) challenging the preoccupation with physical appearances (Duncan & Kennedy, 1992).

Other, less common, group approaches related to eating disorders also appear in the literature. Some involve therapeutic focus on specific aspects of eating disorder etiology, including the differentiation and articulation of affect (Barth, 1994), family of origin/family relations issues (Shekter-Wolfson, Woodside & Lackstrom, 1992), and issues of sexual abuse (Kreidler & Fluharty, 1994; Perry, 1992). McNamara (1989) reports a group process used in a preventive context by providing information and a focus on positive body image to repeat dieters at risk for developing eating disorders.

Etiology

In determining appropriate approaches to treatment for any disorder, an understanding of causal factors is important. This understanding is somewhat elusive in regard to bulimia, however, as the etiology of bulimia nervosa is not conclusive. Theories include a biological model which relates bulimia to physiological, neurological or metabolic disturbances, and a psychosocial model which attributes the disorder to societal pressures to be thin, starting a cycle of distorted eating patterns. A third model, which is a combination of the previous two, asserts that young women who are physiologically predisposed to being overweight or having metabolic imbalances are more susceptible to binging and purging as a response to the undue pressures to be thin (Zimpfer, 1990). Harper-Giuffre (1992) subscribes to the psychosocial theory, stating "Women face multiple, ambiguous, high-achievement-oriented, and often contradictory role expectations that have been precipitated by shifting cultural norms." These role expectations include a "cultural obsession with slenderness" that creates pressure regarding diet and exercise. (p. 11).

Bulimia nervosa has been clearly delineated from the separate, but related, eating disorder of anorexia nervosa; however, a close relationship exists between the two. Anderson (1990)

describes these disorders as existing on a continuum, with bulimia resulting from a failed attempt at anorexia. That is, when the restrictive dieting patterns characteristic of anorexia can not be maintained, the resultant hunger and deprivation triggers a binging episode. In a subsequent continuing cycle of restricting and binging, the binging behavior gradually becomes a response to uncomfortable moods, rather than a response to hunger (Anderson).

Bulimics have been identified as more likely to be identified with narcissistic, histrionic or borderline personality disorders (Anderson, 1990; Schmidt, Tiller & Treasure, 1993). Other characteristics of bulimics include low self-esteem (Kuntz, Groze & Yates, 1992; Romney & Miller, 1988; Zimpfer, 1990) along with feelings of helplessness (Kerr, Skok, & McLaughlin, 1991), dissatisfaction with body size and a distorted image of body size (Kerr et al.; Kuntz et al.; Zimpfer), higher than typical levels of anxiety (Kuntz et al.), and depression (Kerr et al.; Schmidt et al.; Zimpfer). Zimpfer (1990) also noted other psychological issues in bulimics, such as interpersonal sensitivity and sociopathic traits.

Certain family characteristics and environments have also been documented as being associated with bulimia nervosa. These characteristics include tendencies toward conflict and violence, low cohesiveness, emotional distance and detachment, inconsistent displays of emotion and situations of childhood adversity such as alcoholism, abuse or abandonment (Blouin et al., 1994; Harper-Giuffre, 1992; Kerr et al., 1991; Kuntz et al., 1992; Schmidt et al., 1993; Waller, 1994; Zimpfer, 1990).

Wolf and Crowther (1992) identify bulimia as a learned behavior that is reinforced through the reduction of negative emotions which occurs during the binging and purging episodes. Romney and Miller (1988) discuss psychodynamic perspectives of eating disorders which focus on negative parent/child interactions, resulting in a woman's desire to exert control or exact punishment via her body. They also describe behavioral and family systems perspectives, however, and conclude that all positions are involved in forming an effective understanding of eating disorders.

> From our perspective, eating disorders can be understood as a contemporary expression of women's pain. They are learned behaviors--maladaptive coping mechanisms--that express in a culturally syntonic way the intrapsychic pain and dysfunction which arise in the individual as a result of family pathology. (p. 128.)

These theories of causality are important when considering the appropriate approaches to treating the symptoms and etiology of bulimia nervosa.

Theoretical Perspectives in Group Psychotherapy

Research indicates that the predominant theoretical approaches employed in the group treatment of bulimia nervosa are psychodynamic, psychoeducational, behavioral and cognitive-behavioral. The goals, processes, and efficacies of each will be explored separately.

Psychodynamic Psychotherapy

The purpose of the psychodynamic therapy group in treating eating disorders is to address the interpersonal and ego conflicts identified as predisposing factors. In the case of bulimia nervosa, as stated earlier, these conflicts are related to family history, parental interactions, and possible personality disorders, as well as depression and deficits in self-esteem. Psychodynamic groups are long term--sometimes lasting for years--and are typically supplemented by interventions of other kinds, including individual therapy, education and behavioral techniques and medication (Reiss & Rutan, 1992).

The nature of these groups is interpersonal interaction, with no structure imposed in the facilitation. Group members are provided the freedom of self-exploration in an environment that

promotes and sustains personal change. The focus is on affect, in a here-and-now context which allows members to shed false images that they typically use to cope in the world. Members' personalities and ways of interacting in the world are gradually played out in their relationships within the group. In the case of eating disordered members, trust and cohesion of the group may be slow to develop, before the therapeutic work can begin. For this reason, eating disorder groups can take 1 to 2 years to reach termination.

The long-term result of addressing resistant coping mechanisms and distorted cognitions in the group environment is improved self-regulation, and greater autonomy and self-esteem (Harper-Giuffre, MacKenzie & Sivitilli, 1992). Because of the long-term nature of these groups, and the variety of methods that may be employed during the course of or in conjunction with the group, psychodynamic group therapy for eating disorders is difficult to study, and its efficacy has received little attention in the literature.

Psychoeducation

A predominately psychoeducational group approach in the treatment of eating disorders has a major goal of normalizing eating behaviors, which is accomplished by providing extensive information related to the disorder and by educating members on self-care strategies designed to help them monitor their behaviors. The group meetings, led by professionals, are highly structured and more closely resemble a class than a group process. The focus is entirely on the reduction of symptoms and the maintenance of more positive behaviors, and is accomplished in a relatively short period of time (Davis, Olmsted & Rockert, 1992). In their study of the effectiveness of this approach with bulimics, Davis et al. concluded that while the psychoeducational approach had many merits, it had a poor outcome for those bulimics who had high frequencies of vomiting, who had a history of low body weight, or who suffered from severe depression.

Behavioral and Cognitive-Behavioral Psychotherapy

Cognitive-behavioral psychotherapy, as defined by Davis and Olmsted (1992), is the integration of psychoeducational information into a longer series of group meetings where the greater focus is on group processes. In this setting with bulimics, members can serve to examine and challenge one another's beliefs from a cognitive perspective. Members learn to monitor their own thinking and become aware of the dysfunctional beliefs that lead to their bulimic behaviors. In particular, faulty thinking about food, weight, and body shape is exposed and worked through in the group meeting until more realistic interpretations are reached.

Behavioral components of such groups include monitoring of behaviors through regular observation and charting, meal planning, the control of stimuli which prompt binging and purging responses, and problem-solving skills. Cognitive methods focus on understanding, testing, and reframing beliefs about body image, self-worth and appearance, and revealing the relationship between beliefs, affect and behavior. Where psychoeducation places the greatest emphasis on the bulimic's diet and physical disruptions, cognitive-behavioral psychotherapy emphasizes the correction of poor self-concept (Davis & Olmsted, 1992). Thus, control over the intake of food and the underlying beliefs that lead to binging and purging receive comparable consideration in this approach. Additionally, balance is required of the therapist in terms of providing information and facilitating the work of the group on the cognitive issues.

In two different analyses of group treatments for bulimia nervosa, Zimpfer (1990) and Fettes and Peters (1992) identified cognitive-behavioral therapy as the most prevalent approach with this population. Group treatments in general seem to produce effective results in the treatment of bulimia nervosa, when measured in regard to the reduction of or abstinence from binging and purging behaviors. Because most of the groups studied have been cognitive-behavioral in nature,

it would seem logical to conclude that cognitive behavioral therapy is effective. However, it is difficult from the available information to separate the effects of the group process from the effects of the approach; thus, firm conclusions are difficult to draw.

Wolf and Crowther (1992), in an effort to evaluate the cognitive component separate from the behavioral, discovered that each had positive, but different, outcomes in symptom reduction. Behavioral therapy alone was most effective in the reduction of binge eating and related symptoms, while the addition of the cognitive component had a greater impact on the bulimic's preoccupation with dieting and their ability to identify hunger and satiety. An additional outcome of this study was the evidence that both approaches, as brief interventions, apparently sacrificed efficacy in regard to the long-term maintenance of more positive eating patterns. Two additional studies of cognitive-behavioral group therapy (Blouin et al., 1994; Crosby et al., 1993) isolated treatment intensity, defined as the number of therapeutic hours per week, as being most closely related to the long-term reduction of bulimic symptoms in this approach.

A Multimodal Approach to the Treatment of Bulimia

While many of the contributions to the research hold an allegiance to psychoeducational, cognitive-behavioral, or psychodynamic group therapy alone, there is some agreement that a multimodal approach may be more effective in addressing the diverse components of bulimia. This approach would systematically draw from some or all of the theoretical stances in a manner that is specific to the needs of the client and the various facets of the presenting disorder.

A study by Glassman, Rich, Darko and Clarkin (1990) utilized a multi-component treatment program consisting of 4 weeks of intensive therapy. Most of the therapy took place in a group setting with sessions that were 4 hours in duration, and included components of cognitive, behavioral, experiential, and dynamic interventions, as well as once-per-week family support and education groups. Some members were also referred to individual therapy when it was deemed appropriate. The authors report that more than 75% of their subjects obtained significant results from this multi-component psychotherapy.

Fettes and Peters (1992), in their meta-analysis of research on group treatment for bulimia, determined that group therapy combined with additional treatment (which included individual therapy and drug treatments) was more effective than the group therapy alone. However, they acknowledged that for some bulimics, group treatment alone was effective; therefore, the inclusion of additional modes of treatment for bulimic clients should be initiated only after it is apparent that group treatment alone is not enough.

Reiss and Rutan (1992), and Davis and Olmsted (1992) describe similar stepped-care models for the treatment of eating disorders which call for time-limited psychoeducational or cognitive-behavioral group treatments, to be followed with more extensive psychotherapy approaches for non-responders or clients who desired deeper personal exploration. The benefits of this sort of approach are reported to be the cost-effectiveness of the brief therapy approaches, the more immediate focus on the control of distorted eating patterns, and the ability to more effectively match patient needs to treatment options.

> Anderson (1990) also supports the multimodal approach. It is that author's position that Effective psychological treatment [of eating disorders] has three principle characteristics: (1) it focuses on resolution of a central dynamic formulation; (2) it is multimodal in form; (3) it is sequential in its techniques according to the needs of the patient, not the training of the therapist. (p. 148)

Anderson's central dynamic formulation is the result of a therapeutic evaluation of the clients' experiences to determine the primary purpose of the eating disorder in their life. The multimodal format called for involves an integration of individual, group and family therapies. The sequenced

characteristic of the therapy, while designed according to the needs of the client, generally follows a course of educational psychotherapy, then cognitive-behavioral work, and then psychodynamic and existential psychotherapies. The comprehensive nature of this approach is an effort to strike a balance between reducing symptoms and addressing personal growth.

Conclusions

The literature provides evidence that the therapeutic factors of group work--universality, instillation of hope, acceptance, and opportunities for learning and insight--provide a supportive environment in which the bulimic client can safely explore and overcome the distorted thinking patterns and behaviors inherent with their disorder (MacKenzie & Harper-Giuffre, 1992; Yalom, 1995).

Short-term psychoeducational, behavioral and cognitive group approaches are effective in the reduction of bulimic symptoms, in helping members take on more responsibility for maintaining healthy eating patterns, and in the formation of positive self-worth and body image beliefs (Davis & Olmsted, 1992; Davis, Olmsted & Rockert, 1992). While research indicates that cognitive-behavioral approaches are utilized most frequently in the treatment of bulimia (Fettes & Peters, 1992; Zimpfer, 1990), it would seem that they are most effective in the reduction of symptoms, and less proven in the long term maintenance of the new behaviors (Wolf & Crowther, 1992).

Psychodynamic group therapy, as a longer term approach, has its focus on the psychological and interpersonal conflicts that form the etiology of bulimia nervosa. Over time, group members improve in self-esteem, coping skills and autonomy, as well as in their ability to maintain healthy patterns. More permanent change seems to be effected with this approach; its greatest drawback is the time involved (Harper-Giuffre, MacKenzie & Sivitilli, 1992).

Thus, this review of group approaches in the treatment of bulimia nervosa indicates that psychoeducational, behavioral, cognitive-behavioral and psychodynamic groups are all appropriate means through which positive change can occur; however, each would appear to serve different functions and provide different outcomes. A logical argument exists, therefore, for combining these and other approaches in an effort to address all or many of the psychological, physiological and social roots of the disorder. Through the sequenced use of psychoeducation and cognitive-behavioral approaches to gain control of disordered eating behaviors and thought patterns, and psychodynamics to address etiological factors, both symptoms and psychological issues can be impacted with apparent long-term effects.

The benefit to this multimodal approach is believed to be more comprehensive and lasting change for the client who has been caught in a debilitating cycle of binging, purging, and distorted beliefs and perceptions. Drawbacks to multimodal treatment would include the potential for lengthy and expensive treatment, especially in light of the trend toward brief therapy driven by managed care. An additional concern could also be identified in terms of the counselor's skills and preparation. Counselors desiring to provide multimodal treatment for bulimia would need to be versatile in their ability to approach therapy from this variety of theoretical stances and techniques, as well as have a well-developed referral base through which less familiar modes of treatment could be accessed. Skillful assessment of the needs and progress of clients would also be essential to determine the most appropriate course of treatment for each.

Recommendations for further research are warranted in regard to the efficacy of multimodal approaches, and the specific client characteristics to be considered in planning or progressing through a course of treatment.

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Cultural Identity Group Work with Native American College Students

Tarrell L. Portman

This article discusses the use of cultural identity group counseling with Native American college students. A review of the literature related to counseling Native Americans is presented. Group personality as applied to Native American participants is discussed. A model for group work with Native American college students is presented.

The sky looks down on me in aimless blues
The sun glares at me with a questioning light
The mountains tower over me with uncertain shadows
The trees sway in the bewildered breeze
The deer dance in perplexed rhythms
The ants crawl around me in untrusting circles
The birds soar above me with doubtful dips and dives.
They all, in their own way, ask the question,
Who are you, who are you?
I have to admit to them, to myself,
I am an Indian.

"Uncertain Admission"-Frances Bazil

This poem, written by a Coeur d'Alene Indian, won first prize in poetry in the under-sixteen category at the 1965 Scottsdale, Arizona, National Indian Arts Exhibition. Native American students are often uncertain about admitting and accepting their Indian heritage and culture. Counselors can help Native American students to deal with identity development issues. This article will explore using a cultural identity group counseling approach when working with Native American college students.

For the purposes of this article, cultural identity groups are defined as a culturally homogeneous counseling group with a common goal of working on identity issues related to culture. Such groups have experienced success with empowering participants to self-define rather than putting up with the definition assigned to them by others (Brown, Lipford-Sanders, & Shaw, 1995).

Native American college students will be defined in this article as individuals who are enrolled at the undergraduate level in college and define themselves as Native American on admission applications.

Review of Literature

This review of the literature regarding cultural group work in counseling will focus on two areas. Issues relating to the use of group counseling with various homogeneous cultural groups will be explored, as well as issues that are specific to counseling Native Americans.

When members of a counseling group share the same culture, the group is considered to be a homogeneous group (Corey & Corey, 1982; Yalom, 1995). When a specific problem exists,

group cohesion can help, and so homogeneous groups may solidify faster. Thus, when individual identity concerns related to culture are confronted in a group counseling format, with members from the same cultural group, members bond together sooner because of a shared understanding. This solidification allows for more cohesion, provides more 'here-and-now' support to group participants, group attendance is better, less conflict develops, and symptoms are relieved more rapidly (Corey & Corey, 1982; Yalom, 1995). "Although traditional values permeate the lives of many Native Americans, it should be understood that Native Americans are not a homogeneous group. Native Americans differ greatly in their commitment to tribal customs and traditional values through a variance of customs, language, and type of family structure," (Garrett, 1995, p. 188).

Levels of acculturation enter into the group counseling process with group members of the same culture. Leong, Wagner, and Kim (1995) examined the role of culture-specific factors on the expectations of Asian American students to the group counseling process. The results demonstrated that "Asian American acculturation status was a significant predictor of positive orientations toward group counseling, with integrationist status being the primary significant variable," (Leong, Wagner, & Kim, 1995, p. 220).

The use of same-race therapy groups for African American clients on a university campus were conducted with female university students (Steward, 1993). The rationale behind the same-race group composition included a same-race group leader. The purpose was to provide the African American participants the opportunity to experience the sense of visual sameness that Whites do in a mental health setting (Steward, 1993).

Another culture specific group work experience for African American women was called Kujichagulia, which is the Swahili word meaning "self-determination," (Brown, Lipford-Sanders, & Shaw, 1995). This group's goal was to self-define. Group members were encouraged to perceive themselves from an "Afrocentric perspective of interdependence (I am because my sisters exist; my sisters exist, therefore I am)," (Brown et. al., 1995, p. 154). The results were that group participants felt a sense of self and sisterhood in an environment of caring and nurturing Afrocentrism.

Native Americans have a history of group decision making, and may be receptive to group counseling to deal with their personal issues, needs, and concerns (Dufrene & Coleman, 1992). Cultural discontinuity has created difficulties for Native Americans living in the mainstream (Garrett, 1995). Native Americans are a diverse group of peoples which can be acknowledged by 252 languages, 505 federally recognized tribes, and 365 state recognized tribes (Herring, 1990; Thomason, 1991). This creates an atmosphere for the differences between mainstream expectations and the cultural values of Native Americans to surface and increases the need for counseling services that are culturally cognizant to the needs of Native Americans.

Herring (1990) gives six factors that influence counseling efforts with Native Americans. First, the counselor should be aware of world view variances and value differences among Native American groups. Second, the counselor should be open to the unique needs and special problems of the Native American. Third, deeply grounded values and attitudes exist within Native American cultures. Fourth, Native American family structures are different, in that nuclear families are not necessarily traditional. The fifth factor relates to the research on Native Americans. Researchers have been primarily non-Indian and have looked at Native American cultures as deviant. The final area given by Herring was that miscommunication between counselors and Native Americans does occur (Herring, 1990).

Traditional Native American values consist of sharing, cooperation, noninterference, being, the group and extended family, harmony with nature, a time orientation toward living in the present, preference for explanation of natural phenomena according to the supernatural, and a deep respect for elders (Garrett, 1995).

Traditional Native American healing practices have been used by mental health professionals in individual and group counseling; such practices have included: (1) Four Circles - concentric circles of relationship between client and Creator, spouse, family, as a culturally based structural concept for self-understanding; (2) Talking circle - a forum for expressing thoughts and feelings in an environment of total acceptance without time constraints, using sacred objects, the pipe, and prayer; and (3) Sweat lodge - a physical and spiritual self-purification ritual emphasizing the relationship of the human being to all of creation (Heinrich, Corbine, & Thomas, 1990). Counselors should be knowledgable in these practices before attempting to utilize them with groups.

Guidelines for providing group counseling with Native Americans have been presented in the literature by Dufrene and Coleman (1992). These guidelines offer a framework for developing a foundation of group counseling with Native Americans. Additional recommendations on counseling were given by Garrett and Garrett (1994). Respect should be shown to Native American clients by asking permission and expressing thankfulness. Allowing moments of silence and not interrupting a thought are also important. The use of anecdotes, short stories, metaphors and imagery in the counseling session can also be beneficial. The counselor should display patience in the counseling process (Garrett & Garrett, 1994). These recommendations are compatible with Rogers' Person-Centered approach to counseling. Empathy, warmth, and respect can be used to enhance the counseling process.

Conceptual Model for Group Work with Native Americans

The primary difference when working with Native American students in a group is that the "focus stays on the group, and change happens for the entire group rather than for individuals within the group," (Mitchum, 1989, p. 269). In synthesizing the material on counseling Native Americans, group work with Native American college students is explored to help with cultural identity issues that may contribute to low retention rates, lower academic achievement, and a level of cultural discontinuity.

Colleges and universities are a social microcosm of a pluralistic American society (Brown, Lipford-Sanders, & Shaw, 1995). A consolidation of young adult identities is at its peak in the life of a college student (Vinson, 1995). Since the Native American culture credits more value to contribution to the group than on individual success and accomplishments, group counseling seems a logical method of delivery when providing counseling services to Native American students (Mitchum, 1989). A model of counseling Native American college students in a homogeneous group follows.

A Native American cultural identity group is composed of undergraduate students who have self-defined as Native American/American Indian or Alaskan, Aleut, on university admission forms. It is important to note that Pacific Islanders, and Hawaiians are considered indigenous peoples, and should be invited to participate in a separate homogenous group.

A screening of the level of acculturation should be conducted to attempt to get same level participants in the counseling group. This can be accomplished through personal interviews and self-reports on individual history and involvement with Native American traditions. This would allow an opportunity for more group-oriented work toward the goal of identity development.

When at all possible the first choice for the group should be a Native American counselor (Dufrene & Coleman, 1992). A non-Indian counselor who is culturally skilled could facilitate, but should be well trained in the values and world views of the various Native American tribes that will be represented. The non-Indian counselor should have participated in and observed many Native American ceremonies, rituals, and dances prior to ever accepting a group of Native Americans.

The group setting should be as much in harmony with nature as possible, depending on the level of acculturation of each group. A room with windows that provide a connection with natural gardens or scenic views would be an appropriate indoor setting. Distractions should be kept to a minimum. Noninterference from outsiders who are not participating in the group is important. Participants should be arranged in a complete circle with no barriers between them, the circle is sacred to most tribes.

Time limits should not be imposed on the group, but talked through together. Flexibility in group time limitations should be considered. Open movement within the group should also be allowed. It is not uncommon for a Native American to physically withdraw from the group in times of crisis. This would not be questioned by traditional members. The individual would be allowed to return to the group and would be welcomed without an explanation of his or her absence. This is tied to the noninterference value of most Native Americans (Garrett, 1995).

Native American healing rituals and Western counseling must be combined. Dufrene and Coleman (1992) suggest that the group leader can be connected to the role of an "elder, clan leader, or medicine person" leading a Native American group (p. 232). A mirroring of aspects of the Native American culture should be attempted, instead of holding fast to traditional Western group counseling techniques, such as self-disclosure, challenging, and feedback (Mitchum, 1989). Utilization of sacred objects related to the Indian nations represented may be most effective if the counselor works closely with a Native American spiritual leader. The group model should follow the community practices of the Indian groups represented as closely as possible.

The transition stage is traditionally a time when group members challenge each other and/or the leader. Native American group participants are not likely to challenge the leader of the group because of the respect for authority. Medicine people and healers are highly respected within the Native American culture. Using Western methods of providing feedback for individuals in the group may not be effective. The group unity may be used to provide feedback to the whole group. A sense of we-ness is primary. Praise is acceptable when given to the collective group. If the group is successful, the individuals see themselves as successful.

Yalom (1995) points out, "Homogeneous groups jell more quickly, [and] become more cohesive," (p. 255). This stage may occur earlier in a Native American group with members at a similar acculturation level. It is at this time in the group that structured activities might be introduced. The history of Native American ancestry is very important, and storytelling may be vital at this stage. Genealogy used as a counseling tool could be used with the group. Humes (1994) wrote; "Who you really are, in part, is defined by your origins or roots. In our current preoccupation with self-concept and self-worth, an individual might want to make a connection with past events and people in order to help with this process of self-identification," (p. 296). In the development of cultural identity, a connectedness with the past is sought by the clients. The search "leads to a sense of identity, pride, and self-esteem. One of the problems of modern youth is that they don't know who they are and from whence they came," (Humes, 1994, p. 297).

At termination of the group process, members should be reminded that they are going their separate ways but are bound together by the blood they share. This is building on the Native American spiritual dimension in the group process. A ritual or ceremony could be used to embrace the concept of cultural heritage.

Counseling Implications

Native American youth are walking in two worlds--the world of mainstream society and the world of traditional Native American values. The use of group work with Native American students appears to be one of the most compatible methods of counseling this population. When Native American students leave their families and natural support systems, they are faced with

challenges of meeting the expectations of the mainstream culture. Hopefully, these students will seek help from counselors instead of dropping out of school and returning to their family groups.

Counselors should become knowledgeable about Native American values and world views. The counselor should get involved with local Native American groups, if possible, by volunteering services. This would enrich the life of the counselor while the counselor is learning about the everyday life of Native Americans.

The counselor should never forget that the level of acculturation is paramount in counseling Native Americans. Even though Native American clients may report that they are assimilated into the White dominant culture, it does not mean that they have come to terms with their Indian heritage. An integrated or bicultural level is better when walking in two worlds.

The group process itself may take the group work format and yet incorporate a lot of the Native American traditions within the process. The use of co-facilitators who are traditional spiritual leaders or healers may be an effective path to choose. The non-Native American counselor should beware of attempting to use Native American sacred ceremonies, rituals, or objects if not fully instructed by a traditional Native American as more harm than good could occur.

The use of group work with Native Americans has not been fully researched. To truly know the effectiveness of group work with a homogeneous group of Native Americans on college campuses, further research is necessary. It is hoped that counselors will be both practitioners and researchers in group work which explore cultural identity issues with Native Americans.

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Group Interventions with Hispanic Adolescents in Cultural Transition

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This article proposes the use of group interventions as an effective way of addressing the specific needs of Hispanic youth in cultural transition. Relevant data on the use of groups with ethnic minority adolescents, and the unique issues and tasks of immigrant Hispanic adolescents are discussed. A case study of a group of Hispanic adolescents in a ESL program is included as an illustration.

Much of the research with Hispanic adolescents has focused on high-risk groups and problem behaviors, including academic failure, substance abuse, delinquency, acting-out, teenage pregnancy, and, more recently, HIV-related issues (Lovato, Litrownik, Elder, & Nunez-Liriano, 1994; Millan & Chan, 1991; Millan & Ivory, 1994; Smith, McGraw, Crawford, & Costa, 1993; Smith & Weinman, 1995). The use of group interventions with adolescents has received limited research attention. Studies on group applications with Hispanic adolescents are even more scarce.

Hispanic adolescents, in general, are more likely to experience poverty, violence, substance abuse, and teenage pregnancy than non-minority adolescents (Vargas & Willis, 1994). Hispanic adolescents who are recent immigrants are faced with a double challenge. Not only must they master certain developmental tasks, but they must also meet the demands of an imposed cultural transition. They must deal with multiple losses, language difficulties, new roles and conflicting choices. They must also deal with the repercussions of being a minority in American society. The experience of racism and discrimination may be detrimental to the development of a clear ethnic identity and a sense of personal worth.

Such a multitude of risk factors demands increased attention to the development of preventive measures and interventions specifically targeted at Hispanic youth in cultural transition. It is believed that group interventions constitute the most appropriate approach to address the needs of this population. This article discusses the unique tasks that this population must accomplish, as well as relevant data on the use of group interventions with ethnic minority adolescents. A case study of a group for Hispanic adolescents in an ESL program is included.

Hispanic Adolescents in Cultural Transition

Cultural transition is defined as a process that begins when immigrants arrive in the new country and ends when they are comfortable with the new language and cultural values (Baptiste, 1990). Specific transitional issues for the immigrant adolescent include a differential rate of adjustment for family members, isolation from peers, increased parental control and family resistance to the adolescent's acculturation. Problems that can be expected, regardless of the adolescent's ethnicity and social status, include loyalty binds, role conflicts, anger, and depression (Baptiste, 1990).

Hispanic adolescents in cultural transition find themselves torn between the values of the old culture (represented by their parents), and those of the new culture (represented by their peers). They struggle in their attempt to assimilate into the new culture, while remaining loyal to their families. New roles and expectations are created by the demands of the new situation (Baptiste,

1990). The Hispanic adolescent is faced with conflicting choices. While acceptance of the Hispanic heritage may mean having to identify with an oppressed minority, adopting an Anglo identity may involve rejecting values inherent in the Hispanic heritage. The experience of poverty and discrimination may lead to rejection of the new culture, and "may exacerbate normal difficulties in the resolution of identity questions" (Hardy-Fanta & Montana, 1982, p. 352).

Hispanic adolescents typically suffer multiple losses in the process of emigration, including long-term friendships, an established position among their peers, and, often, a loss of social status (Baptiste, 1990). Moving to the United States places the adolescent into a minority status, which is devalued in American society. In addition, they often have difficulty forming new relationships with peers in the new country (Goodenow & Espin, 1993). The experience of racism and discrimination, along with feelings of alienation, may lead to a diminished sense of self-worth. Group interventions may provide the most effective and efficient means to affirm the self esteem and ethnic identity of Hispanic adolescents.

Group Interventions with Hispanic Adolescents

In a survey of research on group counseling with Hispanic adults, Hardy-Fanta and Montana (1982) noted that such groups were often time-limited, and led to improved communication and reduced stress. They concluded that, given that "adolescents grow in groups," it would be safe to assume that group interventions may also be beneficial for the Hispanic adolescent in cultural transition (p. 354). In a study of several short-term therapy groups for Hispanic female adolescents in a bilingual education program, Hardy-Fanta and Montana (1982) found that group participation led to increased ability to tolerate and verbalize conflictual feelings, increased use of mutual support, and decreased impulsive acting-out. Milicic and Gazmuri (1980) discussed a group counseling program for children and adolescents in Chile, designed to increase emotional and social development, as well as interaction with the school system. Participants reported improved communication and increased self-awareness. The authors concluded that the opportunity for interaction and reflection provided by the group increased participants' awareness of self and others, ability to interact, and problem solving skills.

Hispanic adolescents may derive more benefit from group than individual approaches because interdependence and cooperation are highly valued in their culture. The group format may also be less threatening than the individual or family approach. Many of the issues of Hispanic adolescents in cultural transition are most appropriately dealt with in a group setting. The group experience can serve many purposes, including mutual support, ethnic identity affirmation, acculturation, education, and personality change. Participation in a group can be particularly beneficial for those who are feeling isolated, and having problems in the areas of identity, acculturation, and bicultural socialization (Ho, 1992).

Concepts and Expectations of Groups

Traditional psychotherapy groups, particularly in clinical settings, may alienate Hispanic adolescents, who may respond to an invitation to participate with "yo no estoy loco/loca!" (I'm not crazy). Acceptance to participate may trigger a sense of failure and shame. In addition, those who are new immigrants in the United States may find group interaction intimidating and confusing. However, American-born Hispanic adolescents, and those who emigrated during their early childhood, may be more responsive to group participation (Ho, 1992).

The free participation expected in the group may contradict many of the values of Hispanic cultures. Because of the hierarchical nature of Hispanic societies group members may have difficulty understanding the role of the facilitator. According to Ho (1992), Hispanic adolescents tend to view the leader as an authority figure, and expect the facilitator to be active and directive. They may, therefore, adopt a passive and dependent attitude. A strong sense of family loyalty may

make it difficult for these adolescents to talk openly about themselves. Issues of shame and fear related to their immigration status may also impede honest self-expression. In addition, because of a "being-in-becoming" cultural orientation, Hispanic adolescents may resist setting goals and planning for their accomplishment (Ho, 1992). Research (cited in Ho, 1992) on group interventions with ethnic minority adolescents indicates that they are more likely to respond to short-term, clear, and concrete goals and objectives.

Yalom's Therapeutic Factors: Implications

Most research on the presence and manifestation of therapeutic factors has focused on groups of adult patients. Minimal attention has been given to the study of curative elements in children's and adolescents' groups, and almost no attention has been provided to multicultural issues. Yalom (1995) noted that, in multicultural groups that are predominantly Caucasian, "therapists must help the group move past a focus on concrete cultural differences to transcultural responses to human situations and tragedies that all of us share" (p. 7). Yamaguchi (as cited in Ho, 1992) stated that, because of a collectivist orientation, ethnic minority children are better able to develop group cohesiveness than majority children. Ho (1992) added that a strong sense of loyalty, commonly found in ethnic minority cultures, also encourages the development of group cohesiveness.

Brown (1994) discussed the applications of Yalom's therapeutic factors in brief counseling groups for children. Several strategies to foster the development of therapeutic factors were suggested. For example, helping members recognize similarities is one of the ways facilitators can promote a sense of universality in the group. Teaching communication skills, interrupting destructive behaviors, and modeling appropriate disclosure are all conducive to the establishment of group cohesiveness. Asking members to seek and imitate positive models enhances the development of imitative behavior within and outside the group. Group facilitators also need to be attuned to members' existential concerns, and facilitate their expression and understanding. Facilitators can help members increase their acceptance of existential issues by teaching them that these concerns are universal and, to some extent, unresolvable. Ho (1992) added that, asking children to help others in the group, even through simple tasks (e.g. preparing drinks), will enhance their sense of altruism.

Many of these suggestions may be applicable for adolescent groups as well. For the most part, Yalom's therapeutic factors have been treated in the literature as universal elements, without particular regard for gender or cultural differences. Adolescent concerns and issues are generally considered to be fairly universal. The need for accurate information about sexuality, for example, exists in all adolescents (Hardy-Fanta & Montana, 1982). The need to establish significant relationships with peers, and to develop social skills is probably universal. Existential factors and those of universality, cohesiveness, socialization, imitation, and the imparting of information may be particularly relevant for Hispanic adolescents in cultural transition.

Culturally Relevant Approaches: A Brief Overview

A culturally relevant approach is one that is congruent with the individual's values, beliefs, and reality. A culturally sensitive approach must include an understanding of the unique experiences of Hispanic adolescents in cultural transition, as well as the ability to speak their language. The group facilitator must assume an active and directive role, particularly during the initial stages of the group. The facilitator should be open to answering personal questions, in order to increase trust and rapport. Facilitators should pay close attention to subtle changes in non-verbal communication, and to the appropriate pacing of self-disclosure. They must also avoid constant direct eye contact, and use confrontation with caution. Educational or task-oriented groups are more likely to be beneficial than less structured ones. Goals and objectives need to be short-term, clear and concrete. The group facilitator should describe how the group can be used, explain

his/her role clearly, and discuss the importance of self-expression and honest interaction. As part of termination, the facilitator needs to help members review their progress and meaning of their group experience (Ho, 1992).

Case Study

A 12-week group for Hispanic adolescents was conducted by the author, as a requirement for a doctoral course in group counseling. The group consisted of seven (four male and three female) Hispanic ESL students attending a high school in Northwest Arkansas, ranging in age from 15 to 17 years. They were predominantly Spanish-speaking and recent immigrants, with five of the participants living in the United States less than 6 months. Six members were originally from Mexico, and one from El Salvador. None of the participants reported previous experience with groups. The general purpose of the group was to provide a setting where members could address common issues and difficulties related to their experience of immigration, including multiple losses, minority group membership, new roles, and conflicting choices. A goal for the facilitator was to promote and observe the development of therapeutic factors within the group. Goals for members included: (a) increasing coping and social skills in cross-cultural situations; (b) reducing sense of isolation; and (c) enhancing ethnic identity.

Procedure

An initial orientation session was conducted to inform the students of the purpose of the group, and to provide an opportunity for discussion of questions and concerns about the group. A written request for parental authorization, in Spanish, was also given at the orientation session, and included a brief description of the purpose of the group, the possible benefits that students may derive from participation, and some information about the facilitator. Parents were also encouraged to contact either the school or the facilitator if they had further questions about the group.

The group met weekly for approximately 50 minutes in the ESL classroom for 12 consecutive weeks. All meetings were conducted in Spanish by the author, who is bicultural and bilingual. Objectives were delineated for each meeting. A psychoeducational model was used during the first four weeks, followed by a less structured, growth-oriented approach. Art work was occasionally used to encourage self-expression and discussion. The limits of confidentiality and expected roles were discussed in the initial meetings. The importance of self-disclosure and honest interaction was explained and emphasized several times. Specific ways in which the group could be used were described throughout the 12 weeks. Termination issues were openly addressed since the 8th session. Participants were encouraged to assess their progress and personal meaning of their group experience.

Observations

Most group members appeared to readily accept the idea of forming a group. There was some initial confusion about the meaning and purpose of the group, as well as about their role as group members. It appeared that once the members gave the group a name (Union Juvenil Hispana), they were able to identify it as a unique source of support and ethnic identity. This seemed to increase their acceptance of the group experience.

Although the participants had no previous experience with groups, they did not appear to find group interaction confusing or intimidating. Initially, some members expressed feeling "embarrassed" talking about themselves, and confronting others. The female members in the group were more verbal and willing to discuss themselves than the male members. In general, group members expected the facilitator to be active and directive, particularly at the beginning of the group. Although they tended to adopt a passive attitude, group members were able to

acknowledge responsibility for group discussion. Reluctance to participate was often manifested by physical complaints ("I'm tired;" "I have a headache"), and non-verbal behaviors (e.g. posture; yawning). The group appeared to derive as much benefit, if not more, from unstructured sessions as they did from the more task-oriented meetings. Group members resisted setting personal goals for their group experience, which is consistent with the present orientation typically valued in the Hispanic cultures. For the most part, group members appeared interested in one another, and were always respectful and polite. Only the more open and assertive members confronted others occasionally; confrontation was always done in an appropriate manner.

Group members seemed comfortable with each other, and a sense of togetherness was developed early in the life of the group. The female members were particularly warm toward each other, both during and between sessions. The factor of universality appeared especially therapeutic for many group members. Many expressed a sense of relief from knowing that they were not alone, or that their experiences were not unique. A focus on similarities seemed to encourage the development of universality. Other group members also expressed increased hope after learning how others had coped and overcome immigration-related experiences. As the group progressed, existential concerns were revealed, particularly around issues of responsibility. The group also provided members with an opportunity to develop communication skills, particularly in the area of self-disclosure and confrontation. In general, the factors of universality, cohesiveness, instillation of hope, and socialization appeared to be the most relevant or therapeutic for the group. Several group members acknowledged having obtained benefits from the group experience, including increased openness and hope, as well as a reduced sense of isolation.

Typical adolescent issues and concerns were revealed, including dating, teenage pregnancy and parenting, as well as future occupation. The most common themes observed revolved around issues of loss, responsibility and family unity. The majority of group members expressed grief due to separation from family members and friends, as well as over the loss of their previous social life. Many group members also reported a desire to return to their native country. Several members expressed concern about the financial strain on their parents, as well as a commitment to help their families financially. The most common immigration-related difficulties reported included having to share their household with non-family members, and living in overcrowded conditions.

The ability to speak the members' language seemed pivotal in the building of trust and rapport with the group. Many group members expressed surprise and satisfaction from the opportunity to have discussions or other activities in Spanish. The ability to speak the members' first language seemed to have a positive effect on the development of trust and rapport, group dynamics, and, possibly, even group members' self-worth and ethnic identity.

Discussion

Given appropriate preparation, Hispanic adolescents - even those who are recent immigrants, can benefit from group interventions. Prior to the commencement of the group, facilitators need to explain the purpose of the group experience, as well as the possible benefits that may be derived from participation. Group facilitators must clarify expected roles and behaviors, and emphasize the importance of self-disclosure and honest interaction. Group facilitators also need to feel comfortable assuming an active and directive role, particularly during the initial stages of the group. Given that Hispanic adolescents, particularly those who are new immigrants, are not likely to question or confront the facilitator, cueing on non-verbal behaviors and indirect communication (e.g. physical complaints) is extremely important. The ability to speak the group members' language seems essential in the development of trust and rapport. Having an understanding of the unique experiences and common issues of Hispanic adolescents may also be extremely helpful in establishing rapport with this population.

Group interventions may provide the most effective and efficient means to address the needs of many Hispanic adolescents, particularly those who have common issues and experiences. Participation in a group may lead to increased use of mutual support, enhanced awareness of self and others, as well as improved social and communication skills. Participation in a group can be particularly beneficial for those who feel isolated, are still grieving their losses, and question their worth and identity. The ability to maintain a sense of self-worth and develop a clear identity will, ultimately, allow Hispanic adolescents to overcome prejudice, discrimination, and a multitude of risk factors.

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